

PALLIATIVE CARE **IN HOSPITALS** **AN OVERVIEW**

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KEPUTUSAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR : 812/Menkes/SK/VII/2007
TENTANG
KEBIJAKAN PERAWATAN PALIATIF

LATAR BELAKANG:

Meningkatnya jumlah pasien dengan penyakit yang belum dapat disembuhkan baik pada dewasa dan anak seperti penyakit kanker, penyakit degeneratif, penyakit paru obstruktif kronis, cystic fibrosis, stroke, Parkinson, gagal jantung/heart failure, penyakit genetika dan penyakit infeksi seperti HIV/AIDS yang memerlukan perawatan paliatif, disamping kegiatan promotif, preventif, kuratif, dan rehabilitatif.

Incurable

Promotive

Curative

Palliative

Preventive

Rehabilitative





Rumah sakit yang **mampu** memberikan pelayanan perawatan paliatif di Indonesia masih terbatas di 5 (lima) ibu kota propinsi yaitu **Jakarta, Yogyakarta, Surabaya, Denpasar dan Makassar.**

KMK, No: 812/Menkes/SK/VII/2007

WHO Definition of Palliative Care

Palliative care is an approach that **improves** the quality of life of patients and their families facing the problem associated with **life-threatening illness**, through the **prevention and relief of suffering** by means of early identification and impeccable assessment and treatment of **pain and other problems, physical, psychosocial and spiritual.**

(WHO, 2010)

<http://www.who.int/cancer/palliative/definition/en/>

Palliative care:

- provides relief from **pain** and other **distressing symptoms**;
- affirms **life** and regards **dying** as a normal process;
- intends neither to hasten or postpone **death**;
- integrates the **psychological** and **spiritual** aspects of patient care;
- offers **a support system** to help patients live as **actively** as possible until death;
- offers a support system to help **the family cope** during the patients illness and in their own bereavement;
- uses **a team approach** to address the needs of patients and their families, including bereavement counseling, if indicated;
- will **enhance quality of life**, and may also positively influence the course of illness;

Dimensi Kualitas Hidup yang diinginkan pasien paliatif :

1. Penanganan permasalahan fisik (luka, nyeri, mual, muntah, sesak nafas, dan lain-lain)
2. Kemampuan fungsional dalam beraktifitas
3. Kesejahteraan keluarga
4. Kesejahteraan emosional
5. Kemampuan melakukan aktifitas spiritual
6. Kemampuan melakukan fungsi sosial
7. Kepuasan pada layanan terapi
8. Orientasi masa depan (rencana dan harapan)
9. Kehidupan seksual, termasuk gambaran terhadap diri sendiri
10. Kemampuan / fungsi dalam bekerja

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Jennifer J. Clinch, Deborah Dudgeon dan Harvey Schipper (2000)

Palliative care should be initiated when the patient becomes symptomatic of their active, progressive, far-advanced disease and should **never be withheld until such time as all treatment alternatives for the underlying disease have been exhausted.**

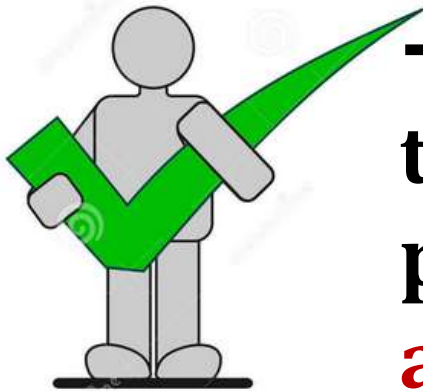
The IAHPD Manual of Palliative Care
3rd Edition

It is **not dependent on prognosis** and can be delivered along with curative treatment.

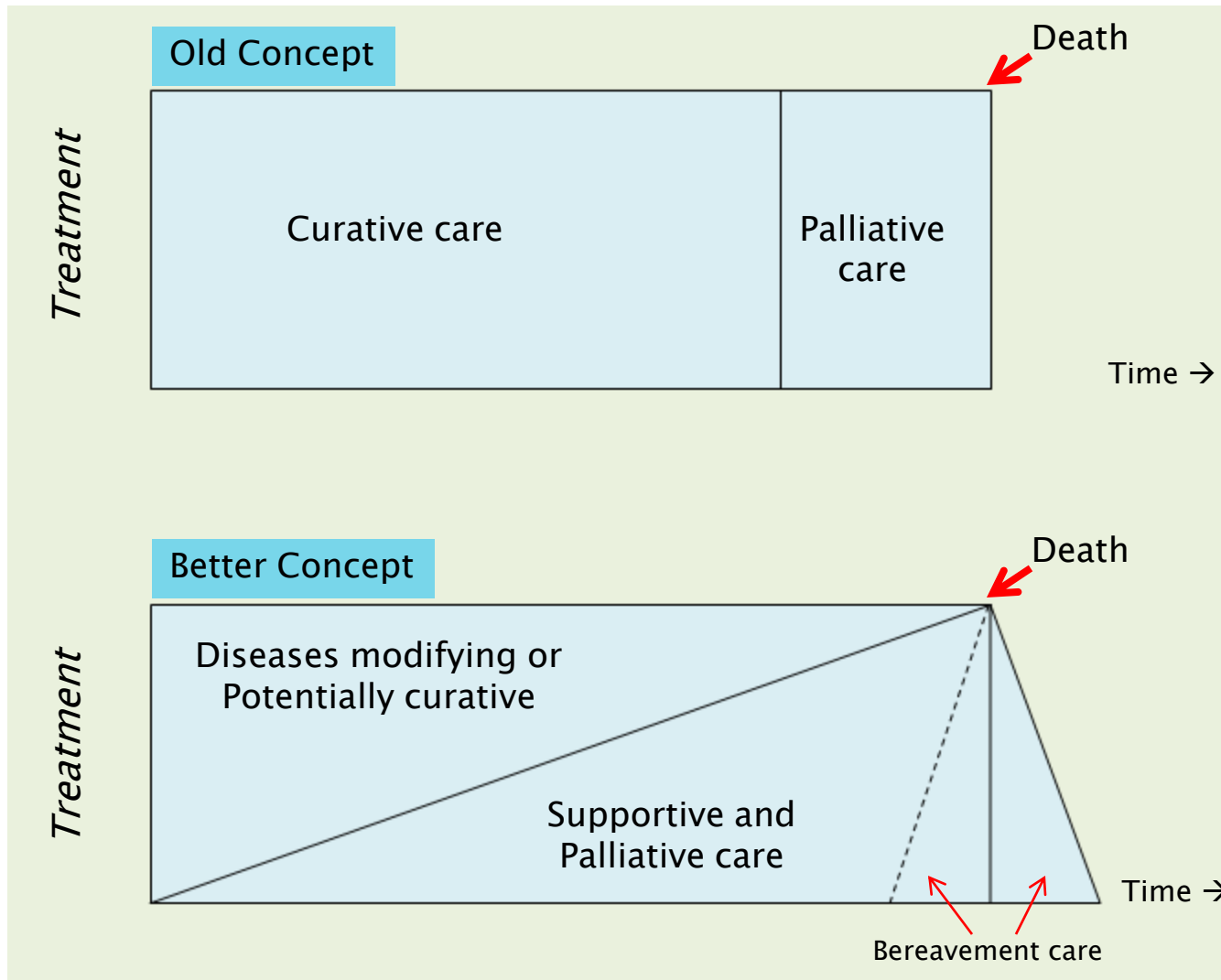
Diane E. Meier, MD



Many health care workers believe that palliative care is the "soft option" adopted when "active" therapy stops!

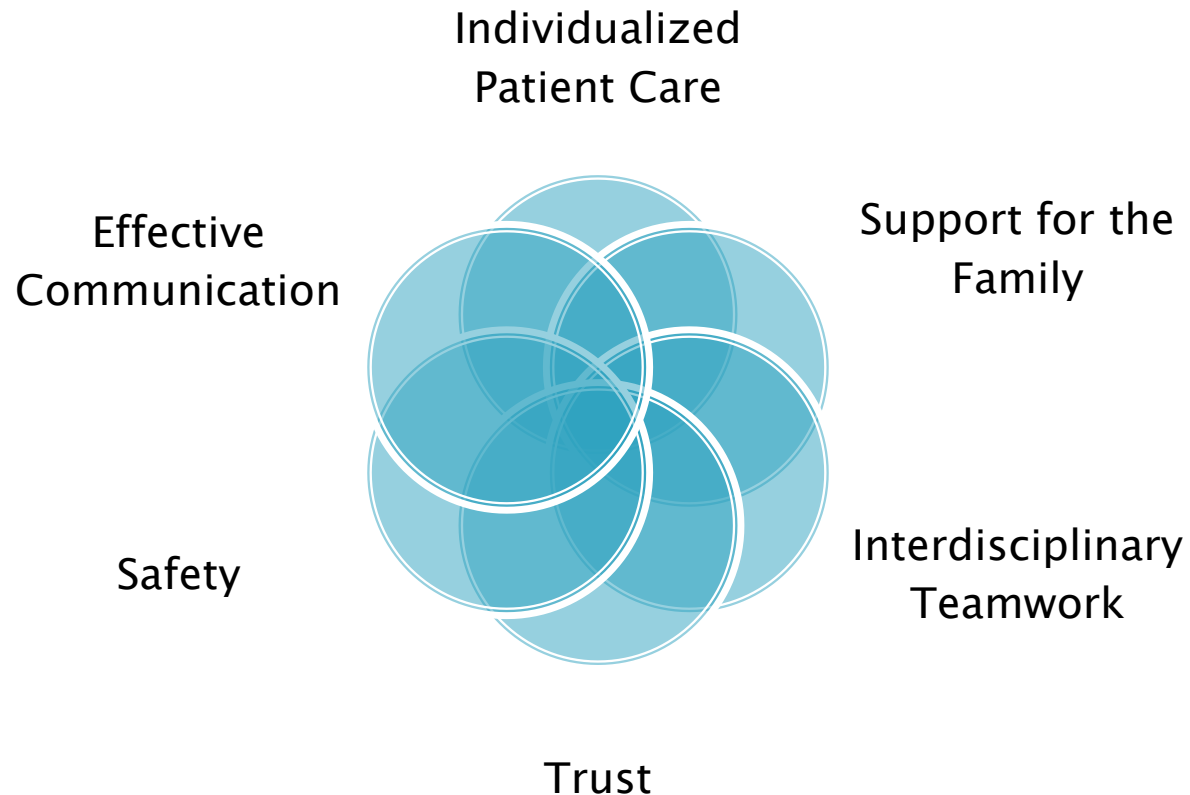


→ **Palliative care**, addressing all the patient's physical and psychosocial problems, is **active therapy**



Murray SA, Kendall M, Boyd K, Sheikh A.
 Illness trajectories and palliative care.
 BMJ. 2005; 330:1007-1011.

ATTRIBUTES

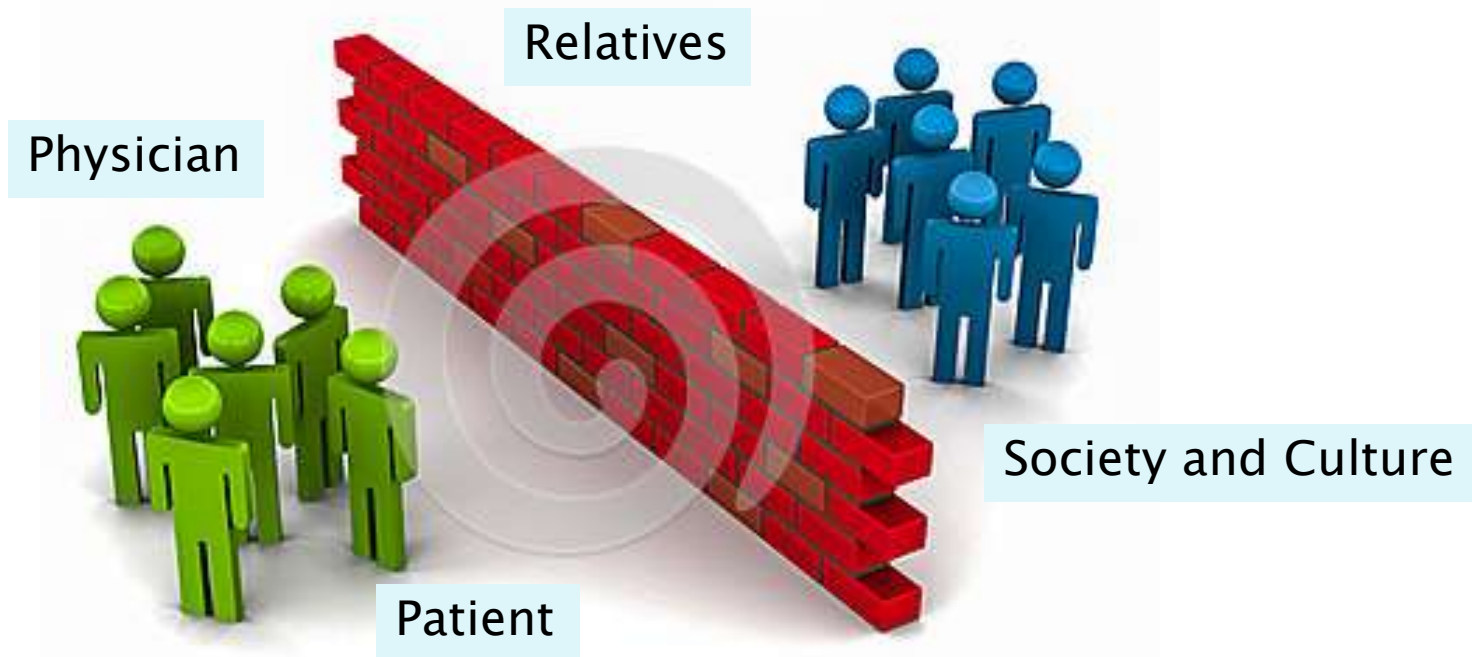


Karen Davis, RN, BSN, OCN

Interdisciplinary Teamwork

- ▶ Many different health care professionals are involved in palliative care programs:
physicians, nurses, social workers, chaplains, nurse aides, dieticians and **volunteers**.
- ▶ All members of the palliative care team **work together**, along with the patient and family, to create **the best goals of care** for the patient.

BARRIERS to PALLIATIVE CARE



dreamstime.com

Barriers related to the physician

- **poor prognostication**: does not recognise how advanced the patient's illness is
- may not recognise how much the patient is suffering
- lacks communication skills to address end-of-life issues
- believe they are already providing good palliative care and need no assistance
- **misunderstands** what a palliative care service does or has to offer
- does not want to hand over the patient's care: **loss of control, loss of income**
- opiophobia: worries the patient may become addicted to opioids or suffer severe side effects
- does not believe in palliative care
- **does not know of the palliative care service**



The IAHPC Manual of Palliative Care
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THE **MYTHS** ABOUT PALLIATIVE CARE

Myth: Palliative care = just end-of-life care

We often help patients whose life expectancy is good

Myth: Palliative care = just pain management

We could help manage challenging cases and symptoms

Myth: Palliative care = “no more treatment”

We assess the values & goals a patient, designing care around them

Suzana Makowski, MD MMM FACP

Palliative care improves quality

Compared to conventional care, palliative care is associated with:

- Reduction in pain and non-pain symptoms
- Improved patient/family satisfaction
- Reduced hospital length of stay and cost

Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003; Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002.

THE WALL STREET JOURNAL.

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Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

Palliative-Care Unit
Offers Painkillers and
Support, Fewer
Tests, Treatments

Wall Street journal (Eastern ed.) 04/2004;

GAUTAM NAIK
Diane E. Meier, MD

Care, Not Cure

Average cost for terminally ill patients in
palliative and nonpalliative programs
during their final five days at one hospital

	NON-PCU	PCU
Drugs and chemotherapy	\$2,267	\$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
Total	\$12,319	\$5,313

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: Virginia Commonwealth University medical center

ORIGINAL INVESTIGATION

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of \$1696 in direct costs per admission ($P = .004$) and \$279 in direct costs per day ($P < .001$) including sig-

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.

Arch Intern Med. 2008;168(16):1783-1790



FINANCIAL CHALLENGES

For Hospital-Based Palliative Care Programs

by J. Brian Cassel, PhD

VCU Medical Center

attributed the cost savings to:

- 77 percent reduction in **drug costs**
- 95 percent reduction in **lab and imaging costs**
- 60 percent reduction in **hospital supplies**

Virginia Commonwealth University (VCU)

FINANCIAL CHALLENGES

For Hospital-Based Palliative Care Programs

by J. Brian Cassel, PhD

Five Common Misconceptions about Palliative Care

1. Our hospital budget is tight right now, and we can't afford another new program.
2. A small palliative care team with part-time staff cannot possibly pay for itself.
3. Palliative care programs are financially feasible for large academic medical centers, but not for smaller community cancer centers.
4. If a palliative care program reduces healthcare costs, won't it also reduce the hospital's revenue stream?
5. Our hospital and cancer center are profitable, so adding a palliative care program using the "financial" or "cost-avoidance" argument may not carry much weight with our administration.

Oncology Issues, May/June 2007

End of Life



Chrisye



Nira Stania



dr. Abdul Mun'im Idries, SpF

Dying is a 4D activity

Physical

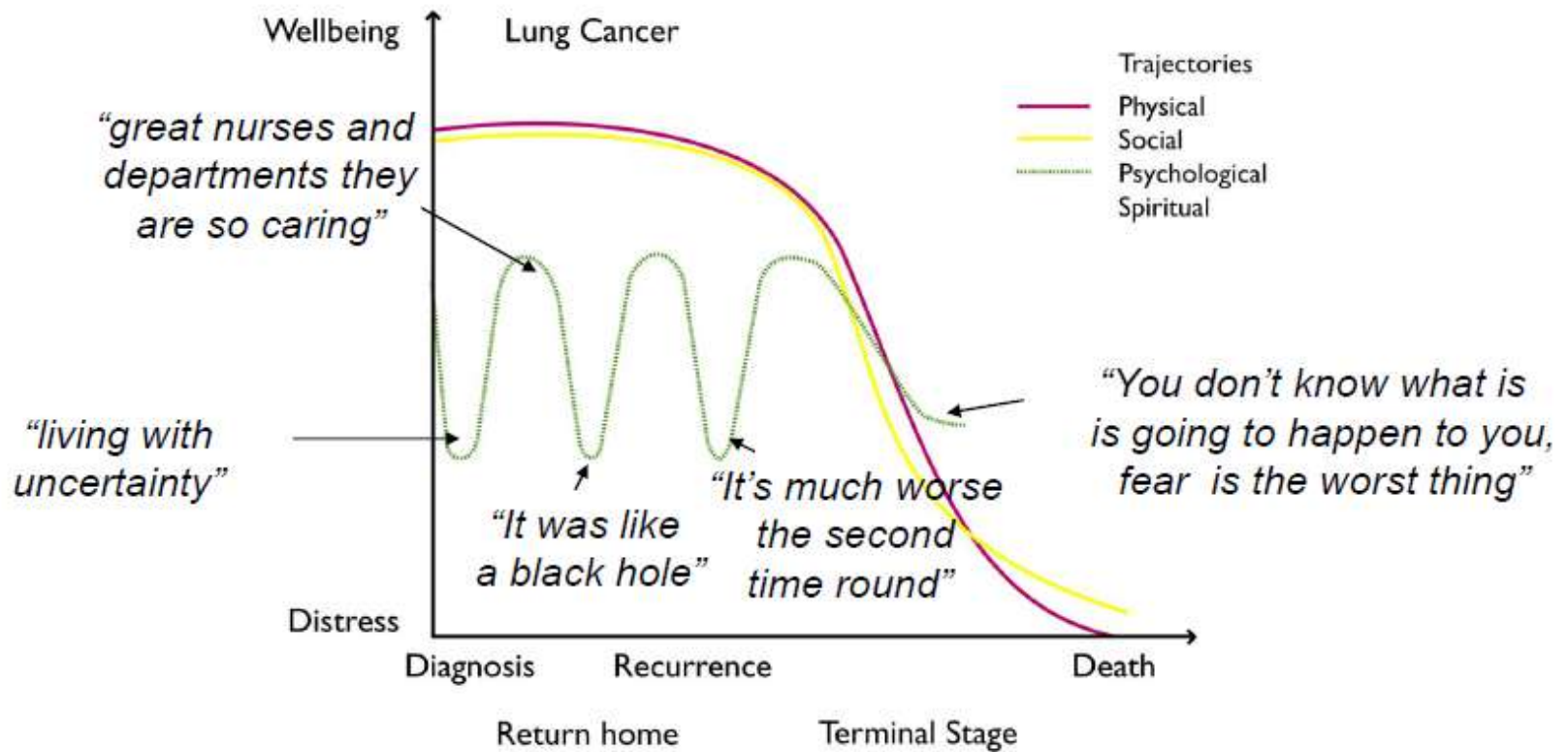
Psychological

Social

Spiritual

Scott A Murray (2010)
Concept of trajectories at the end of life: physical and other dimensions.

Murray SA, Kendall M, Grant E, Boyd K, Barclay S, Sheikh A.
 Patterns of social psychological and spiritual decline towards
 the end of life in lung cancer **J Pain Symp Man 2007; 34: 393-402**



“To cure sometimes, to relieve often, and to comfort always,”

Oxford Textbook of Palliative Medicine
Second Edition

Terima Kasih

